CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, authorize ____ to
(Mental Health/Substance Use Services/Local Management Entity/Managed Care Organization)

disclose to____
(Name of County Department of Social Services or designated Work First agency)

The following information:

(Applicant/Recipient needs to initial each category that applies.)

_______ My name and other personal identifying information
_______ Assessment
_______ Dates of services
_______ Recommendations for treatment
_______ Progress and compliance
_______ Progress and compliance with treatment
_______ Attendance
_______ Date of discharge and discharge status
_______ Discharge plan
_______ Employment and training related information

The purpose of these disclosures is to: Provide permission to the above named MH/SAS/LME/MCO provider to disclose information as initialed to the above named county department of social services either orally or in written format for the evaluation of Work First and Food and Nutrition Services Program eligibility.

For Substance Use: I understand that my records are protected under federal regulations, 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time.

For Mental Health: I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time.

Protected Health Information:
I understand that my alcohol and/or drug treatment records are protected under Federal regulations, 42 C.F.R. Part 2 Confidentiality and Drug Abuse Patient Records, and 45 C.F.R. Parts 160& 164, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Unless otherwise provided by federal regulations, information from alcohol and/or drug treatment records cannot be disclosed without my written consent. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on the consent. I understand that generally ____
(Name of treatment program)
may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

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The North Carolina Division of Social Services does not discriminate against any person on the basis of race, color, natural origin, sex, age, religion, political beliefs, or disability in the admission, treatment, or participation in its programs, services and activities, or in employment.

If I do not rescind this consent, it expires automatically as follows:

1. Upon my termination from the Work First Program, and/or the Food and Nutrition Services Program;
2. Or one year from the date this consent is signed; whichever occurs first.

______________________________ ______________

Applicant/Recipient Signature Date signed

______________________________ ______________

Witness Signature Date Signed

Applicant/Recipient received a copy of this consent form for his/her records. Yes / No (circle one)

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